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Original Communication

Characteristics of victims of violence admitted to a specialized medico-legal unit in Switzerland

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ABSTRACT

To improve care and services to victims of interpersonal violence, a medico-legal consultation unit was set up at the Lausanne University Hospital, Switzerland in 2006. Adult victims of violence are referred to the consultation by the emergency department. Patients are received by forensic nurses for support, forensic examination and community orientation. A descriptive study of medical reports filled for the 2006 population was conducted in 2007 with the aim to explore characteristics of this specific population and to better orient prevention.

Among the 422 patients in 2006, 57% were men and 43% women, with a median age of 31 years old. Violent episodes took place in a public place for 90% of male victims and at home for 70% of female victims. The perpetrators were mostly unknown to male victims (62% of all men victims) and mostly known (usually the partner or a former partner) to female victims (90% of all women victims). For 80% of the women and 47% of the men, the violent event which brought them to the consultation, was not the first one.

Because 90% of all patients under study were victimized by men., not only is it necessary to target prevention program to match the potential victims, prevention messages must also focus on potential offenders, especially on young men.

1. Introduction

Interpersonal violence, as defined by the World Health Organization (WHO),[1] is an emerging public health issue in developed countries.[2] Switzerland, often regarded as a peaceful and highly developed country, is not an exception. Thus, 10% of all men and 8% of all women living in Switzerland and aged 16 years and older reported violence during the last 12 months. The economic burden of violence is estimated at more than 400 million CHF per year[3] and 10.5% of women experienced physical or sexual violence in a domestic context at least once in their lives.

Among all medical services, emergency departments (EDs) are the ones that are the most concerned by this issue. In the last 10 years, the ED in our hospital saw an important increase in cases related to interpersonal violence, underlined by an ever-mounting number of medical reports.[4] To address this problem, a prevention program was set up in 2000, involving the ED, the Institute of Social and Preventive Medicine, the Institute of Legal Medicine, the Department of Justice and Police, the womens' shelter, and specialized social services, among others.

The prevalence study conducted to initiate the program, showed that regardless of the actual reason for consulting, 11% of the ED patients reported violence during the previous 12 months.[5] This high prevalence rate helped convince political and institutional decision makers to sustain the program. Interdisciplinary experts were asked to produce appropriate guidelines and an extensive educational campaign was launched in most hospital services. These initiatives contributed to raising the awareness and the involvement of professionals inside and outside the hospital. At the same time, the services offered to victims by local institutions were examined by a panel of experts specialized in the prevention of violence. As a result of all these activities, it became obvious that there was a need for an accessible forensic services to help victims of interpersonal violence. To address this shortcoming, a new medico-legal unit, the violence medical unit (VMU)[6] was created in our hospital in 2006. The VMU combines medico-legal and community competences and services in accordance with WHO recommendations aimed at improving access to medico-legal services, using complementary

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community oriented services. The VMU consultation is open every morning (365 days a year) and caters to adult men or women, aged 16 years and above, that have been subjected to physical and/or psychological interpersonal violence. Sexual violence is not dealt with at the VMU and is instead referred to the gynaecological department of the hospital. Violent events occurring in any setting (familial, community, professional, institutional) are considered, whether they are isolated or part of a chronically violent relationship. Patients are usually referred to the VMU by the emergency department (ED) of the hospital, and occasionally by police, general practitioners, and other local institutions. The consultation takes place after the first line treatment. Initially, it offers the patient an opportunity to speak freely about his or her own violence history in a calm setting. This is important because the factual and contextual clarification of the violent event is an important factor in the prevention of possible psychic consequences. In a second phase, the inflicted violence is investigated by recording the patient's history, carrying out a physical examination, and carefully establishing a medico-legal documentation of subjective complaints and objective lesions. Finally, in an assessment phase carried out with the patient, his or her priority needs and available resources are identified. The objective is to provide the best possible support and follow-up which is necessarily outside of the VMU consultation. Epidemiological data are routinely collected in electronic files. All VMU activities are carried out by forensic nursing staff supervised by forensic medical doctors.

After its first year of activity, a study of the VMU was carried out in 2007. The objectives were to learn more about the population visiting the consultation and to improve prevention programs inside and outside our hospital. Here, we describe VMU patient characteristics and examine some questions raised by the first year of what can be considered an experiment.

2. Patients and methods

The protocol of the retrospective study was approved by the local ethics committee in March 2007. Data were collected from medical files completed by nurses for every patient who visited the VMU from January 03 to December 31, 2006. Eligibility criteria included the availability of a complete medical file and a consultation related to current interpersonal violence victimization. The analysis was restricted to baseline characteristics of the victims (age, nationality, religion, working and marital status, abuse in childhood) and of the violent events (domestic, community or institutional violence, gender and number of offenders, level of acquaintance between victim and offender, site of violent event, history of previous violent events). When necessary, data were supplemented with information collected during the admission procedure.

A database was created using EPIDATA (version 3.1). Statistical analysis was conducted using SPSS (version 15.0).

3. Results

According to the administrative data at hand, a total of 435 patients were admitted to the VMU consultation between January 3 and December 12, 2006.

The final study sample consisted of 422 cases, of which 56.6% were men and 43.3% women. Age ranged from 16 to 86 years in men (median age: 29 years) and 16–72 years in women (median age: 32 years). In 66.1% of the cases, the patients were younger than 35 years. Some 57% were nationals of other countries than Switzerland. Violence in childhood was reported in 11% of men and 20% of women, but was absent in 60% of all cases.

Table 1
Main socio demographic characteristics of the VMU patient population.

Variables	Male		Female		
	n	% of men (*n* = 239)	*n*	% of women (*n* = 183)	Total (*n* = 422)
Age category (years)					
16–34	166	69.5	113	61.7	66.1
35–54	55	27.2	59	32.2	29.4
⩾55	8	3.3	11	6	4,5
Marital status					
Single	140	58.6	60	32.8	46.9
Divorced/ separated	24	10	42	23	7.8
Married	72	30.1	74	40.4	34.6
Widowed	0	0.0	6	3.3	1.4
Unknown	3	1.3	1	0.5	0.9
Nationality					
Swiss	113	47.3	65	35.5	42.2
Non swiss	125	52.3	117	63.9	57.3
Unknown	1	0.4	1	0.5	0.5

Variables and modalities that characterize violent events were selected according to WHO recommendations.[7] Thus, institutional violence (violence in a professional context) was included in community violence (no familial relationship between the perpetrator and the victim) and partner violence was included in family violence. For the purpose of discussion, partner violence was handled as an isolated type.

Community violence cases were twice as common as family violence. Some 90% of men reported community violence and 70% of women complained of family violence. Partner violence was reported by 8% of all men.

The place of occurrence partially reflected these data, with 60% of women and only 13% of men aggressed inside the home. In contrast, 46% of men and only 11.5% of women were aggressed in a bar, pub, discotheque or some form of public transportation.

Table 2
Main characteristics of the violent event.

Variables	Males		Females		
	n	% of men (*n* = 239)	*n*	% of women (*n* = 183)	% Total (*n* = 422)
Type of violence					
Community violence	212	88.7	56	30.6	63.5
Family violence	27	11.3	128	69.9	36.7
Of which partner violence	*19*	*7.9*	*115*	*62.8*	*31.8*
Place of occurrence					
Patient's home	20	8.4	80	43.7	23.7
Anyone's home	11	4.6	22	12.0	7.8
Bar, restaurants, disco	90	37.7	18	9.8	25.6
Public transportation	20	8.4	3	1.6	5.5
Other	98	41.0	56	30.6	36.5
Unknown	0	0.0	4	2.2	0.9
Gender of the offender					
Male	205	85.8	155	84.7	85.3
Female	24	10.0	20	10.9	10.4
Mixed (several offenders)	6	2.5	7	3.8	3.1
Unknown	3	1.3	2	0.5	1.2
Offender					
Known	90	37.7	163	89.1	60.2
Unknown	147	61.5	20	10.9	39.8

In 85% of all cases, offenders were men, 90% of the women knew their assailants, whereas 61.5% of the men did not.

For 80% of the women and 47% of the men, the violent event that led to the consultation was preceded by other violent events.

As assessed by nurses or recorded during direct questioning of consulting patients, one or more children were involved in a quarter of all cases (80 women and 20 men). In 90% of cases involving children, the children abuse and neglect team (CANTeam) of the hospital was alerted in order to assess the needs and take specific measures to ensure child safety.

Following consultation at the VMU, 90% of the victims were referred to a specialized center for legal, psychological and social support to crime victims, with 85% actually taking advantage of this possibility.[8] In addition, 24% of the women and 19% of the men were referred to the hospital psychiatric service and 30% of the women were referred to a specialized women's shelter. (See Tables 1 and 2).

4. Discussion

The following parameters characterize the 2006 VMU patient population: a higher number of consultations for women, a higher number of community violence cases compared to family violence, a higher number of foreign nationals compared to Swiss citizens, and a generally young population, despite the presence of a few out layers for age. Compared to the population studied in 2002[9] that was admitted to the ED of the same hospital because of a violent event, and as revealed by the Pearson Chi-square test, the population studied here presented no differences for gender or type of violence, but was significantly younger ($p < 0.001$) and comprising more non Swiss patients ($p = 0.002$).

Compared to the population of the city of Lausanne in 2006, the proportion of young people and non Swiss citizens was higher in the patient population (30% aged from 15 to 34 years in Lausanne versus 66% in the study population; 39% of Lausanne inhabitants are non Swiss, versus 57% for the studied population).[10]

The age bias may be explained by the fact that young people engage in more violent interactions than older people. At the same time, it may also reflect a change in mentality and a generational culture phenomenon where young people are more likely to demand medico-legal documents in order to pursue legal action. Conversely, the older population may be living in a quieter context and enjoying more peaceful relationships. It is also possible, however, that older people may be underestimating the gravity of their situation or may be unwilling either to disclose their suffering, or to have medico-legal documentation completed by specialists.

Several hypotheses can be made regarding the overrepresentation of non Swiss citizens in the VMU patient population. Thus, for some ethnic groups, violence in immigrant communities may find its origins in a culture-inherited violent way of life. It may also be explained by social and economic stressors in a context of high vulnerability, or as by a selection effect of migrant populations in relation to voluntary or involuntary migration processes, etc. Any in-depth discussion of this aspect is beyond the scope of the present report. This is particularly true because "data about the nationality of victims do not provide information on the nationality of offenders". Finally, immigrants also have a tendency consult the ED more often than Swiss patients who prefer to consult a private family doctor. All these findings indicate that caution should be exercised when interpreting the obtained results, if at all.

Male VMU patients were more prone to community violence, while women were essentially affected by domestic violence. Such distinction was by no means absolute: 11% of men reported domestic violence and 31% of women were involved in community violence.

In 90% of all cases, women knew their aggressors. Being victimized by an unknown person was indeed quite exceptional in the population studied. This finding is in complete contradiction with the common representation of places that are a dangerous for women, such as being alone on the street at night or travelling alone in a subway. Such situations are indeed statistically less dangerous than engaging in a violent relationship with a partner or an ex-partner at home.[11–13]

For half of the men in the study, the violent situation for which they were consulting was not the first violent episode in their adult life. This finding supports the hypothesis of a "violent lifestyle paradigm" in young people that put themselves in danger, get involved in brawls as victims or perpetrators, and possibly engage in violent partner interactions.[14]

Previous violent events were also reported by more than three quarters of women. If one accepts the violence cycle theory,[15] this finding may be explained by the fact that these women were seeking help after a rather long series of violent events because danger was increasing or because they believed that children needed to be protected. The latter possibility may be discussed in the light of the finding that children were involved in 44% of the female VMU cases.

The modalities chosen for the variable "place of occurrence" were insufficient. Thus, violent events occurring on the pavement in front of a club were not registered as "restaurant, club, disco" events. Similarly, violent events occurring on the step of the door or in the corridor of the house were not registered as "home" events. This may explain the significant proportion of "others".

The proposed follow-up of victims by the local interdisciplinary network appears quite effective. Indeed, 85% of the patients referred to the specialized social and legal service were actually helped by this service.

5. Limitations

This research has several limitations. Thus, the absence of identical VMU services at other hospitals prevents any comparison. The absence of any monitoring of referred patients by the hospital ED is also a shortcoming. At the same time, data quality may not be homogenous because of a lack of experience of some forensic nurses. The most important limitation stems from the all too frequent absence of a "reliable denominator" and of an "external validation" in the monitoring process of interpersonal violence. Thus, some victims may be monitored by police or legal statistics, others by the ED or some forensic services, some by social services or women's shelters and some are simply invisible, even in mortality statistics, due to cultural taboos.

It may thus be of interest to carefully describe, explore and follow-up a homogenous population (such as the VMU population) in order to identify trends and evolutions in interpersonal violence. Annual monitoring of the VMU population is planned with this objective in mind.

6. Conclusions

An overwhelming proportion of women in the VMU population under study were victims of offenders that were well-known to them, with the violent acts taking place at their own homes. Over 90% of the aggressors resorting to any kind of violence were men, with the median age of the aggressor being 32 years. This finding is certainly the most interesting result of this study. Indeed, because a large part of interpersonal violence occurs between people within the same age range,[16] it seems not only important to target prevention programs so that they can reach potential victims, but also to focus on potential offenders, and especially young men.

7. Future research

An initial assessment of patient satisfaction, use of the medico-legal documentation and expectations of the VMU and other professionals providing care to victims, has been carried out in 2008. Results will be available in 2009.

Even though some methodological difficulties may be encountered, it may be quite interesting to conduct a follow-up study to assess the medium term impact on patients of VMU consultations and perhaps uncover unexpected and/or adverse effects. Finally, it may also be worthwhile to investigate possible links between involvement in recurrent community violence and acting out domestic violence. This may help determine whether perpetrators of violence are as violent in a community setting as in a domestic one.

Conflicting of interest

All authors declare that they have no competing interests therefore have nothing to disclose.

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Ethical approval

None declared.

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